California MEDICINE

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EDITORIAL

The National Library of Medicine

WE FIND OURSELVES, paradoxically, hoping for the passage of proposed legislation that would remove the world's greatest medical library from the management of those who have brought it to its present proud estate and put it into other hands.

We speak here, of course, of this country's Armed Forces Medical Library and of a bill (S. 3430) recently introduced in the Senate by Senators Lister Hill of Alabama and Joseph F. Kennedy of Massachusetts which would turn that priceless facility over to a newly created National Library of Medicine.

Often in a proposal for a change of management there is implication of reproof. Not so in the present case. On the contrary, the purpose of the proposed transplanting is to assure that the library will always have the special attention it deserves.

Behind the new legislation is a recommendation made more than a year ago by the Task Force on Federal Medical Services to the Commission on Organization of the Executive Branch of the Government (Hoover Commission). The Task Force noted that although originally organized for military use, the library now far surpasses, in nature, size, and level of activities, the needs of the Armed Forces and "is in fact the National Library of Medicine of the United States." Even as it now stands, it is virtually a *sine qua non* of orderly, well directed medical research.

Expressing concern for the well-being of the library in the years ahead, the Task Force pointed out that so far as money to support it is concerned, as a creature of the Armed Forces it must in peacetime compete with the needs of the military to maintain the skeleton of an effective fighting force and "in time of war it becomes naive to expect the preoccupation of the military to include the proper maintenance and continuing development" of the institution. Even now the library needs better housing and the funds are not forthcoming. And this is a matter of immediate and compelling importance, for a large part of its historical collection of medical publications—ineffably valuable, since it is irreplaceable—abides uneasily in a building that is in a poor state of repair and almost wantonly susceptible to fire.

To make sure the library would never have to go hungry in event of budget-stretching economies, the Task Force recommended making it a principal function of another government agency rather than an incidental operation of the Armed Forces—great though it has grown in that habitat. The legislative bill, as it was presented to the Senate, did not specify what department of the Federal Government shall have supervision, but in some quarters the Department of Health, Education and Welfare has been suggested. The recommendation of the Task Force was that the Smithsonian Institution might best serve in the management of the library. However, putting the library into the hands of the Department of Health, Education and Welfare would seem to be a way to the same end, and we favor passage of the bill in any form that would assure the preservation and promote the growth of this great national asset.

Physicians will recognize at once that the library, directly or indirectly, serves all who do medical research, all who practice medicine and, ultimately, all who benefit from research and practice. Here, then, is a bill (S. 3430) that all of us can heartily endorse. Here, too, is a splendid opportunity for each of us to communicate to our elected representatives in Washington our earnest interest in the passage of medical legislation that will benefit all the nation.

One more thought, rather apart from stern practicality, that seems to need expressing is this:

Even though the purpose of the proposed transfer of the library is in itself a tacit tribute to its excellence, we wonder if something more direct cannot be done to ease the emotional wrench that the Army must feel at the separation of this old comrade in arms. Perhaps the bill, when it reaches its final form, can include specific provision for a suitable memorial to the Surgeons General of the Army who nurtured the library from its beginning in 1836—particularly a recognition of the work of the late John Shaw Billings, who from 1865 when he was assigned to the office of the Surgeon General of the Army until his retirement from the service in 1895, gave to the library the zeal of creativeness.

Editorial Comment...

The Use of Physical Therapists and Allied Personnel in Medical Practice

THE CLASSIFICATIONS of persons without medical degrees who may lawfully attend the sick and injured in this state are unfortunately large. Some of these paramedical or adjunctive medical personnel possess training and knowledge of great potential benefit to the practicing physician and his patient. These include registered physical therapists* and registered occupational therapists. Other such legally franchised groups represent cultism ranging from harmless to harmful and from inexpensive to formidable commercial exploitation. Some alleged "physical therapists" (usually self styled as physiotherapists) are little better than "physical culturists."

Originally, qualified physical therapists were hospital personnel only. In recent years increasing numbers of them have opened their own offices for "private practice" of physical therapy. No law prevents their doing so, although various councils of the American Medical Association have repeatedly disapproved. There is a considerable difference between "private practice" and having a physical therapist a member of a medical group, paid by salary, owning no equipment and unlisted in the telephone directory. Although the therapist in "private practice" invariably prefers to work under referral and orders from a physician, the pressure—often abetted by patients—to prescribe and treat directly is unavoidably high.

What can the conscientious physician do to minimize the obvious dangers in these circumstances?

1. He can first of all keep informed concerning the training and qualifications of paramedical personnel.

2. He can refer patients only to ethical, qualified therapists who refuse to prescribe for the patient off the street. If possible he should use salaried hospital staff therapists rather than those in business on their own. Well-trained therapists are usually diplomates of the American Registry of Physical Therapists and members of the American Physical Therapy Association.

3. He should provide the therapist with a diagnosis, hazards or dangers involved, objective to be gained and a clear and detailed physical therapy prescription. "Give the patient heat and massage" is equivalent to saying, "Do whatever you want." Further, the physician must follow his patient, make sure what treatment he is actually getting and not let it continue indefinitely.

4. When perplexed about either diagnosis or treatment the practitioner should not attempt to make a consultant of the therapist but should solicit opinion of specialists qualified in the particular field.

5. Perplexities can usually be resolved by applying the standard: What is best for my patient?

This editorial comment was prepared as a joint effort of the Northern California Society of Physical Medicine and Rehabilitation. The persons included are: S. M. Dorinson, M. D., Frances Baker, M.D., Gregory Bard, M.D., Karl Carlson, M.D., William Northway, M.D., Gerald G. Hirschberg, M.D., Sedgwick Mead, M.D., and Raoul Psaki, M.D.

*Note the distinction in this state between "registered" and "licensed" physical therapists. Only registered physical therapists and occupational therapists are required to graduate from schools approved by the Council on Medical Education and Hospitals of the A.M.A.